



The Missouri Department of Health and Senior Services provides services on a non-discriminatory basis. Difference in treatment in provision of services because of race, creed, religion, national origin, ancestry, sex, age or disability is prohibited by law. If you believe that you have been discriminated against in one or more of these areas you may file a complaint with the Department or the U.S. Department of Health and Human Services by completing this complaint form and returning it to one of the following agencies:

Missouri Department of Health and Senior Services
Office of Personnel
Compliance Coordinator
P.O. Box 570
Jefferson City, MO 65102-0570

U.S. Department of Health and Human Services
Office of Civil Rights
601 E. 12th Street, Room 248
Kansas City, MO 64106
816/426-7277
TTD: 816/426-3724

If you have applied for, or are participating in the WIC Supplemental Food Program you may also contact the: Administrator, Food and Nutrition Service, U.S. Department of Agriculture, 3101 Park Center Drive, Alexandria, VA 22302.

If you wish to file a complaint with the Department of Health and Senior Services, please answer the following questions with as much detail as possible.

1. NAME (MR./MRS./MS.)	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

2. DESCRIBE WHAT OCCURRED TO MAKE YOU BELIEVE THAT YOU WERE TREATED DIFFERENTLY THAN OTHER CLIENTS AND THE DATE THE INCIDENTS OCCURRED.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

3. DO YOU BELIEVE THAT THE DIFFERENCE IN TREATMENT WAS BASED ON YOUR:

☐ RACE OR COLOR ☐ DISABILITY ☐ SEX ☐ NATIONAL ORIGIN ☐ AGE ☐ RELIGION ☐ OTHER

Why do you believe that your membership in one or more of these categories was the reason for the difference in treatment? (If 'other' is checked, please explain what you believe to be the basis for the difference in treatment.)

4. Provide the name of the agency and/or person(s) who are responsible in the alleged difference in treatment.

AGENCY NAME

ADDRESS (STREET, CITY, STATE, ZIP CODE)

PERSON(S) INVOLVED

5. Did you report what happened to you to anyone at that agency? ☐ Yes ☐ No

If yes, provide the name of the person(s) you talked with and what you reported to that person.

6. Do you know of anyone else who was treated in the same manner as you or anyone who witnessed what happened to you?

☐ Yes ☐ No If yes, provide the name of the person, their address and telephone number, and what happened to them.

If more space is needed to fully explain what occurred, please attach additional information to this form.

SIGNATURE

DATE